Open access

Ordering tests is easy, but a specialist's opinion may be more valuable

See p 634

A specialist ought to be someone who, by virtue of training and experience, can assess and advise patients and referring doctors with the optimum—which often means the minimum—use of investigations. A specialist whose main function is ordering tests is simply acting as a middle man (or woman) between the general practitioner and the service department, and such intermediaries can usually be dispensed with. With open access to hospital investigations general practitioners can dispense with some specialists, and, unsurprisingly, open access has not been universally welcomed as a proper means of offering health care.

Of course, some investigations must be reserved for specialists. These include invasive procedures entailing risk and requiring dexterity and those that are either very expensive or very time consuming (and hence need rationing by specialists, who know which patients are most likely to benefit). Few doctors want open access cardiac catheterisation for patients with chest pain or open access computed tomography for patients with headaches. But there seems no reason to deprive general practitioners of open access to techniques that are non-invasive, harmless, reliable, and cheap and can be carried out by a technician. For patients with cardiovascular problems the value of both open access exercise testing and echocardiography has been described.

Direct access to exercise testing was offered to 122 general practitioners in Belfast, and over two years 192 patients (a remarkably small number) were assessed.¹ Only 18% of tests gave positive results. Open access to hospital services for general practitioners may save money by reducing attendances at clinics,² but the cost of open access can be considerable. No money will be saved if a small fall in referrals to clinics is outweighed by a huge rise in investigations.

Whether the exercise testing service in Belfast reduced the workload of hospitals was not clear, as most of the positive results were in patients who the general practitioner thought were likely to have angina, and many patients with negative results would probably never have been referred to a hospital or clinic. Nevertheless, the general practitioners and patients presumably found the negative result reassuring, and management of the patients' problems may well have been made easier.

On page 634 Francis and colleagues describe the use made by general practitioners in Edinburgh of open access to echocardiography.³ Here the aim was to limit the service to patients thought to have heart failure, or at least to patients suspected of having impaired left ventricular function;

referrals for other reasons were considered "inappropriate." Of 119 patients who were being treated for heart failure, nearly half were thought on the basis of their echocardiogram not to need treatment at all. Although the need for angiotensin converting enzyme inhibitors was confirmed in 34 patients, the main value of the examination seems to have been that it encouraged the withdrawal of unnecessary and undesirable drugs. This confirms the findings of a small community study of patients being treated with loop diuretics for heart failure in general practice, in which about half were found on echocardiography to have normal hearts.⁴

Despite this high rate of inappropriate treatment little doubt can exist that most patients with heart failure are inadequately investigated and treated. In a community survey in Nottingham 505 patients being treated with loop diuretics were identified, but only half of these were found to satisfy clinical criteria for heart failure.⁵ Of those who seemed to have heart failure, three quarters had been referred to hospital but only a third had echocardiography. Of those prescribed loop diuretics but without clear evidence of failure, only 9% had ever been referred.

As a result of this study open access echocardiography has been offered to general practitioners in Nottingham for the past two years, and about 1000 patients have been studied without prior assessment by a cardiologist. General practitioners have been encouraged to use the service not only to elucidate the cause of heart failure but also to help explain breathlessness and to assess the importance of a heart murmur. About half the investigations have yielded normal results: impaired left ventricular function has been the most common abnormality, but some 4% of patients have been found to have aortic stenosis with a valve gradient of over 50 mm Hg (J Richardson, personal communication).

Reassurance, but at what cost?

Whether these open access services detect enough patients with treatable abnormalities to make them worth while is a matter for debate; as the experience in Edinburgh shows, a normal result not only reassures patients and doctors but also allows the withdrawal of unnecessary treatment. But the proportion of abnormal results in these studies seems reasonable, and general practitioners seem to be using the facilities responsibly. The question then is how far can open access go?

Now that the British Society of Gastroenterology has agreed in principle that diagnostic endoscopy can be per-

formed by trained nurses, widespread open access endoscopy cannot be far away; some districts already have an open access service staffed by doctors.⁶ Hopefully, however, all new open access services will be carefully assessed before they become widespread: the definition of a successful service is one in which the test replaces the need for a specialist opinion. The more a test can be reported in simple numerical terms the more suited it is to open access; the more a report depends on opinion the more important that it is made in the light of a clinical assessment of the patient. One of the problems of both open access exercise testing and echocardiography is couching reports in terms that general practitioners can use in patient management. As with all open access investigations the key to optimal use is strict guidelines agreed between specialists and general practitioners.

In general, investigations are simultaneously becoming more sophisticated and yet simpler to carry out. If open access goes too far there is a danger that general practitioners will find themselves weighed down by data that they find hard to interpret. General practitioners who seek an opinion need to refer their patients to a clinic, not simply to send them to

hospital for a test. Specialists must not simply be gatekeepers for investigations; it is their opinions about clinical problems that make them useful.

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Advance directives

Like a will, everybody should have one

The moral duty to respect autonomy is now an established part of good clinical practice.¹ Patients have the legal right to decide whether or not they will allow themselves to be touched for the purposes of medical treatment. Consequently, they also have the right to refuse proposed treatments, even when doctors believe that such treatments are in their best interests.² The most dramatic example of such refusal is the rejection of life saving treatment.

Doctors often find it hard to accept that patients might prefer death to clinical care, especially when they are incompetent and cannot speak for themselves. If doubts exist about what a competent patient wants or needs, they can be discussed when they arise. Since incompetence precludes such debate, the duty of care must be guided by consideration of the patient's best interest.³ Where a clear consensus exists about the positive effects of treatment this provides an appropriate basis for clinical care. But when such agreement does not exist doctors may face intolerable moral and legal indeterminacy.

The classic cases of such indeterminacy usually concern decisions not to treat patients. It is now accepted that circumstances exist in which not providing lifesaving treatment is professionally and legally acceptable.⁴ Examples include those in which treatment is futile or patients are irreversibly close to death or have extreme brain damage. Yet doctors are rightly conservative about how these situations should be interpreted. Mistakes about non-treatment cannot be corrected and might give rise to legal action.

This conservatism has led to incompetent patients sometimes being kept alive in circumstances when, had they been competent, they would have preferred to die. The consequences have been distressing for relatives, doctors, and sometimes the patients themselves.

Against this background comes *Mental Incapacity*, published last week by the Law Commission.⁵ The commission endorses the principle of what it calls "advance statements about

health" (that is, advance directives or living wills) and recommends supporting legislation. There is little doubt that, given recent developments in case law, such statements already have legal force in Britain.⁶ To remove any possibility of ambiguity, however, the commission argues that statute law should clearly stipulate the means by which competent people of 18 and over can exert control over medical treatment if they become incompetent patients.

Of course, this right to consent does not extend to determining either the type or amount of treatment to be offered.⁷ Though the views of patients should be taken into account, such provision is ultimately a matter of clinical and managerial discretion. Consequently, the most important conclusion of the commission concerns what it calls "advance refusals"—statements that prohibit life sustaining treatments should the patient become incompetent.

The commission argues that such refusals should

- Be made by people competent to do so—able to understand, retain, and act on the information on which the refusal is based
- Be presumed to be valid if signed and witnessed
- Be revocable if the patient is competent to revoke them
- Explicitly state the author's awareness that death might or will be the result of the refusal
- Be suspended if being assessed by a court for validity
- Not preclude the provision of basic care, defined as the maintenance of bodily cleanliness, relief of sustained and serious pain, and the provision of oral nutrition and hydration
- Not be deliberately ignored, such action being a criminal offence.

These are sensible proposals and should be enacted in law. Doctors will then be more likely to acquaint themselves with advance refusals and to discuss with patients any options concerning non-treatment.⁸ The quality of care for incom-